Name* _____ **Today's Date** _____

Sex* □Male □Female **Age** _____ **Date of Birth*** _____

Reason for office visit _____

Current medical conditions*

- □ Anxiety
- □ Arthritis
- □ Asthma
- □ Atrial Fibrillation
- □ Bone Marrow Transplant
- □ BPH
- □ Breast Cancer
- □ Colon Cancer
- □ COPD
- □ Coronary Artery Disease
- □ Depression
- □ Diabetes
- □ End Stage Renal Disease
- □ GERD (acid reflux)
- □ Hearing Loss
- □ Hepatitis
- □ High blood pressure
- □ HIV/AIDS
- □ High cholesterol
- □ Hyperthyroidism
- □ Hypothyroidism
- □ Leukemia
- □ Lung Cancer
- □ Lymphoma
- □ Prostate Cancer
- □ Radiation treatment
- □ Seizures
- □ Stroke
- □ Other_____
- □ Other_____

Past Surgeries* (Include date / type)

- □ Appendix _____
- □ Breast_____
- □ Colon _____
- □ Gallbladder _____
- □ Heart _____
- □ Joint replacement _____
- □ Prostate _____
- □ Skin _____
- □ Uterus_____
- □ Tubal ligation _____
- □ C-Section_____
- □ Other_____

Past skin conditions* (Include date and location for cancers)

- □ Acne _____
- □ AKs (actinic keratoses) _____
- □ Basal Cell Cancer _____
- □ Blistering sunburns _____
- □ Dry Skin _____
- □ Eczema _____
- □ Flaking/ itching scalp _____
- □ Allergies _____
- □ Melanoma _____
- □ Atypical or dysplastic moles _____
- □ Psoriasis _____
- □ Squamous Cell Cancer_____
- □ Other

Do you wear sunscreen □Yes □No SPF_____ Do you use a tanning salon □Yes □No
Do you have a family history of Melanoma skin cancer?* □Yes □No Relative _____

Medications* (including aspirin and supplements) *Please indicate dosage strength, form, and quantity

_____ _____
_____ _____
_____ _____

Allergies* (to medication or other)_____

Do you smoke cigarettes?* □Yes □No **Have you ever smoked cigarettes?*** □Yes □No
Alcohol consumption per week _____ **Do you exercise?** □Yes □No

Occupation and workplace _____
Place of Residence (Town/type of building) _____

Blood thinner/Bleeding Problems	□Yes	□No	Pacemaker or Defibrillator	□Yes	□No
Pregnancy / planning pregnancy	□Yes	□No	Artificial joints	□Yes	□No
Immunosuppressed	□Yes	□No	Lidocaine or epinephrine allergy	□Yes	□No

DermatologyArts

832 102nd Avenue NE
Bellevue, WA 98004
Phone: 425-753-2918
Fax: 425-333-7389

1701 Creekside Loop #120
Yakima, WA 98902
Phone: 509-853-7546
Fax: 509-852-7565

Last Name* _____ **First Name*** _____ **MI**_____

Today's Date_____ **Date of Birth*** _____ **Age**_____

Other/Previous Names _____ **SSN** _____

Mailing Address* _____
City, State* _____ **Zip Code*** _____

Mobile #* _____ **Home #**_____

E-mail* _____ **Preferred Language**_____
Sex □Male □Female **Ethnicity**_____ **Marital Status**_____

Primary Care Physician* _____

Location_____ **Phone** _____

Preferred Pharmacy* _____

Location*_____ **Phone**_____

Emergency Contact* _____

Relation* _____ **Phone*** _____

Permission to disclose health care information to family members:
If you would like us to share your health care information with any family members or friends, please list names / contact information so we may disclose biopsy results, lab results, or other confidential information if you are unavailable.

Contact_____

Relation_____ **Phone** _____

Notice of Privacy Practices Reviewed Acknowledgment
By signing below, I am acknowledging I have reviewed this office's Notice of Privacy Practices currently in effect, which explains how my medical information will be used and disclosed. I understand this is available at dermatologyarts.com or in a written copy upon my request.

_____ _____
Signature of Patient* **Date***

_____ _____
Signature of Insured and/or Legal Guardian **Date**

Name*_____

Authorization to release information and assignment of benefits
The undersigned authorizes the release of any information relating to all claims for benefits submitted for dependents or myself and agree that my signature below authorizes claims submitted for services rendered. I hereby authorize my insurance company to pay and assign directly to Dermatology Arts all reimbursement benefits payable under my insurance policy.

I understand that I am financially responsible for all charges incurred, and if the insurance does not pay within 45 days, the balance is due from me. If my insurance is an HMO and I do not present a referral from my PCP (primary care provider) at the time of service, I agree to be responsible for any charges denied by my insurance company due to non-presentation of a referral from my PCP or pre-authorized from my workers compensation insurance company (if I present as a workers compensation patient).

I hereby authorize Dermatology Arts to release by mail, telephone, and/or fax any medical or incidental information that may be necessary for either medical care or processing applications for financial benefits.

I certify that the information given by me is correct. I understand that fees for all the services provided by Dermatology Arts are due at the time services are rendered unless other arrangements have been made and that I am in agreement with the financial and privacy policies currently in effect.

_____ _____
Signature of Patient* **Date***

_____ _____
Signature of Insured and/or Legal Guardian **Date**

Insurance Information
If you have insurance through your spouse's, parent's, or domestic partner's employer, please fill out the information below. If you have insurance through your own employer, please leave blank.

_____ _____
Name of Insurance Subscriber **Relationship to Patient**

_____
Insurance Subscriber's Date of Birth